PARTNERS HEALTHCARE | FOUNDED BY BRIGHAM AND WOMEN'S HOSPITAL AND MASSACHUSETTS GENERAL HOSPITAL

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Gary L. Gottlieb, M.D., M.B.A.
President and Chief Executive Officer
Partners HealthCare System, Inc.

Professor of Psychiatry
Harvard Medical School

Commissioner David Morales
Division of Health Care Finance and Policy
2 Boylston Street
Boston, MA 02116

Dear Commissioner Morales and other members of the panel:

My name is Dr. Gary Gottlieb, and I am the President and Chief Executive Officer of Partners HealthCare. Partners HealthCare is an integrated health system founded by Brigham and Women's Hospital and Massachusetts General Hospital. In addition to its two academic medical centers, the Partners system includes community and specialty hospitals, community health centers, a physician network, home health and long-term care services, and other health-related entities. Partners is one of the nation's leading biomedical research organizations and a principal teaching affiliate of Harvard Medical School. Partners HealthCare is a non-profit organization, employing more than 50,000 individuals.

I am a psychiatrist, specializing in geriatric psychiatry. I trained in New York City, and then spent fifteen years in Philadelphia. My responsibilities there included leadership of psychiatry at an academic medical center, running the nation's oldest psychiatric hospital, and providing managed mental health and substance abuse services for more than 400,000 people. In 1998, I came to Boston, recruited to be the first Chairman of Partners Psychiatry and Mental Health. I have served in several roles across the Partners HealthCare system. Before my current position, I was the President and CEO of Brigham and Women's Hospital.

I want to thank you for the invitation to participate in this important public conversation. As we open this dialogue on solutions, let us keep our focus on the priority - how best to deliver care to patients, their families, and our communities.

We want to be a **partner** in an examination of all possible solutions. Today I am here to offer new ideas and reinforce attributes of others. Our collective mission is to prevent illness, disability and disease and to heal and treat the sick and injured while working to ease pain and find cures.

The health care system has evolved over nearly two centuries with an emphasis on diagnosis and treatment rather than prevention and ongoing care. Public and private insurance models have been designed to indemnify individuals from catastrophic costs through sharing risk across broad communities of people, with budgets generally established based on historic costs and actuarial underwriting. The parallel and

Partners HealthCare System, Inc., Prudential Tower, Suite 1150, 800 Boylston Street, Boston, Massachusetts 02199-8001
Tel: 617 278-1004, Fax: 617 278-1047, Email: ggottlieb@partners.org

seemingly unrelated design and pricing of employer based private insurance and public programs result in unintended risk sharing and cost shifting among payers.

Moreover, unfettered fee for service payments have rewarded high intensity care of the seriously ill and the rapid dissemination of advanced technologies. These payments have also created the need to cross subsidize the under-reimbursed care of people with complex chronic illnesses.

Therefore, a narrow analysis of commercial insurance premiums and prices provides modest guidance to a more complex problem. Unlike a retail commodity, prices for individual health care services reflect a complex web of interactions aimed to support the costs of a broad array of services and activities, some of which may not be reimbursed at all.

The greatest opportunity for rapid cost reduction is also potentially the most humane, patient and family centered. Analysis of Medicare data shows that 10% of beneficiaries account for approximately 70% of costs. These individuals are severely ill, suffering multiple medical comorbidities, and many are near the end of their lives. A good number are also Medicaid eligible. Social, economic and behavioral challenges often complicate effective medical care and add significant costs. Every employer-based insured population has similar groups.

Under the current health care system, care for this population is generally fragmented, addressing immediate and specific demands and circumstances rather than the whole of their personal and family needs. The absence of coordination results in care that is unplanned and reactive. Care is also often inconsistent with best practices, patient centeredness and the most effective use of resources. Therefore, developing and implementing innovative approaches to managing the proper care for this vulnerable patient population is crucial. Even modest improvements will lead to a significant reduction in costs, reducing both commercial and public payments. But even beyond the potential financial impact, we should be doing this because it is the right thing to do.

There are several examples of successful programs which should be evaluated and rapidly scaled so that measurable improvements and cost savings can accrue in a timely manner:

(1) For several years, the state's Senior Care Options program has combined Medicaid and Medicare funds for high risk dual eligible patients to centralize resources to improve care. Through this mechanism, Commonwealth Care Alliance has developed a terrific model which has improved the quality of care while accruing significant savings.

(2) Massachusetts General Hospital is in the third year of a Medicare demonstration project, which is managing care for 2500 high risk Medicare patients under a shared savings model. The program has embedded case managers in primary care offices who follow these patients and try to help them solve problems before they become medical emergencies. MGH invested in this and other care coordination infrastructure and agreed to pay for it out of savings achieved by more efficient, effective care of their patients. They have succeeded in both improving care and accruing savings to the Medicare program. The demonstration project has been renewed with expanded enrollment and is rolling out to Brigham and Women's Hospital and North Shore Medical Center. We're currently evaluating whether aspects of this approach could be applicable to a commercial population for implementation more broadly.

(3) The Prevention and Access to Care and Treatment program, or PACT, is also focused on high-risk patients, but a different population: isolated low income HIV/AIDS patients. Based on the work of Partners In Health in Haiti and Rwanda, the PACT program in Boston employs tightly supervised community health workers to provide and coordinate care for these patients who struggle with their daily care needs and who access the health care system sporadically and expensively. PACT workers develop strong relationships with patients, accompany them to appointments, and provide or arrange for home-based services. The results of this program to date are promising: reduced hospitalizations and reduced overall health expenses (a $5,000 investment per patient avoids $30,000 in costs), based on our experience with 230 patients enrolled for at least one year. In January, in collaboration with Commonwealth Care Alliance and Network Health, the program was expanded to focus on the care of about 1500 chronically ill people with diabetes and other disorders who have been using the most resources in Network Health's Cambridge and Somerville population.

Potential solutions to our collective challenges come in many forms. Some of the programs I have highlighted are either growing or maturing. Here are some ideas that can be implemented more rapidly:

Fee for service contracts should have a reasonable component of reimbursement connected directly to performance measures tied to outcomes, quality, and patient experience.

We should examine bundled payments – a single risk-adjusted payment would cover the costs of clinically-defined episodes of care, which can be chronic or acute. These payments cover the full range of services needed to treat the patient, including hospitalization, physician services, rehabilitation services and readmissions for the same condition.

Bundled payments create an incentive for hospitals, post-acute facilities, and physicians to coordinate care, and also provide an opportunity to engage patients more deeply, especially those with chronic conditions. They also require major changes for both providers and insurers. In order to implement bundled payments, insurers and providers need to be able to develop adequate bundled payments and employers need to consider changes to their benefit designs. An increasing number of bundled payments can serve as a test run for capitation, as these have similar incentives and require cooperation among many providers. Bundled payment strategies could save from $685M to $39.3B over ten years.

And as a final step, if interim evaluations indicate its feasibility and advisability, the system should consider moving to a gradual broader adoption of global payments. Provider organizations would be paid a fixed risk-adjusted payment that covers all the costs of care for a certain period of time for a population of patients. As with bundled payments, insurers and providers need to be able to develop adequate global capitation payments and employers need to change their benefit designs.

Strategies would also need to be developed for managing risk issues, as insurance risk would be shifted from insurers to providers. Many decisions would need to be made about what level of provider risk is acceptable and what level of reserves need to be held. Providers would need to be able to successfully manage the risk that they hold under capitation, including what care their patients receive, when they receive it, and from

whom. Capitation allows for the least amount of patient choice. Therefore, we all would have to prepare the public to accept some limitation of choice in exchange for the quality and cost benefits. Lastly we must guard against the perverse incentive of capitation to do less – a complete reversal of fee for service and no better place for the patient.

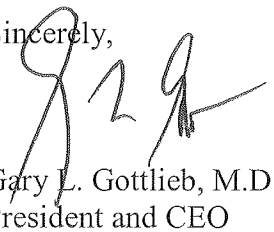
And as with any new initiatives, we must measure their effects comprehensively. Robust evaluation is critical.

In all of these efforts, our main focus needs to be what is best for our patients, how can we help them manage their care effectively and efficiently.

I will conclude by saying that none of this work to transform our health care system can be done alone. Just as our health care system developed over time, and just as we all share some responsibility for the continued growth in health care costs, whether it is through how we provide, how we insure, how we purchase, or how we consume health care, we – providers, insurers, employers, and consumers, and the government – all share some responsibility for finding solutions. We believe that a shared approach, which will require change and sacrifice from all of us, will be the key to the successful transformation of our health care system into one that focuses on value for the patient, their families and the communities we serve.

Again, thank you for inviting me here today. We look forward to continuing this important conversation.

Sincerely,



Gary L. Gottlieb, M.D., M.B.A.
President and CEO